



## OFFICE POLICIES AND INFORMATION

### **Lynn Victory RD, MA, LD, LPC** **Licensed Professional Counselor & Registered Dietitian**

Welcome to my practice. I am looking forward to meeting you. Please read the following information carefully and bring your questions or concerns to your first appointment.

**APPOINTMENTS:** Appointments may be scheduled, changed or cancelled by calling or texting (864) 631-1035. Sessions typically run 50-60 minutes.

**\*NOTICE: If you are unable to keep an appointment, please give 24 hours notice to avoid a \$75 fee. If you reschedule in the same week you will not be charged.**

**FEES:** The fee for individual, couple or family sessions is \$125 per session. Telephone consultations lasting more than 10 minutes will be charged the customary rate, proportionate to the time used. Some sessions may be scheduled for longer than 50-60 minutes. In such case, the time will be prorated based on the standard session rate of \$125 per session. Payment is expected on the day of your session and can be paid via check, HSA card, and cash or debit/credit card. A \$5.00 processing fee will be added when using credit cards. \*Please see important information regarding insurance.

**INSURANCE: \*Our office does not file insurance claims.** Cash, check and all major credit cards accepted for payment. You will be provided with a form that will serve as your receipt and a coded insurance form for you to file if you wish.

**\*It is up to each patient to determine if your insurance company will cover our services.**

**PARK:** Please park in the lot next to the Cottage. If that lot is full proceed to the driveway on the right directly after the Cottage. You can access the Cottage from the back steps and proceed to the waiting area on the top floor. Make yourself comfortable, help yourself to a beverage and I will greet you in the lobby.

**ETHICS:** I closely follow the code of ethics of the following boards and organizations:

- The South Carolina Board of Examiners for Counselors, Therapists and Psycho-Educational Counselors.
- American Dietetics Association

**CONFIDENTIALITY:** Information shared during your sessions will be held in the strictest of confidence. All information revealed by you in a counseling or therapy session and most information placed in your personal file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper or oral]) is considered “protected health information” by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). As such, your protected health information **cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.**

The \*exceptions to this are defined below.

Situations in which your **consent is not required** to share your personal health information:

- Uses and disclosures required by law- i.e.: *files subpoenaed by a Judge official*
- *Uses and disclosures about victims of abuse, neglect or domestic violence- i.e.: The duty to warn when someone is likely to endanger his/her life or the lives of others, child sexual or physical abuse, elder abuse, etc.*
- Uses and disclosure for judicial and administrative proceedings- i.e.: *A case where you are claiming malpractice or breach of ethics.*
- Uses and disclosures for health and oversight activities- i.e.: *Correcting records or Correcting records already disclosed.*
- Uses and disclosures for law enforcement purposes – i.e.: *When you claim mental health issues as a defense in a civil or criminal case.*
- Uses and disclosures for research purposes- i.e.: *Using client information in Research; always maintaining confidentiality.*
- Uses and disclosures to avert a serious threat to health or safety- i.e.: *Calling Probate Court for a commitment hearing.*
- Uses and disclosures for Workers' Compensation- i.e.: *The basic information Obtained in therapy/counseling as a result of your Workers' Compensation claim.*

## **BENEFITS and CONSEQUENCES OF PSYCHOTHERAPY & NUTRITION THERAPY:**

Individuals contemplating counseling should be aware that clients frequently make significant changes in their lives. People often modify their emotions, attitudes, beliefs and behaviors. Clients may make changes in their marriages or other relationships. As a result of counseling, clients may change employment, begin to feel differently about them and alter significant aspects of their lives to better serve themselves. If you have questions about the benefits and consequences of counseling, please feel free to address them with me.

In compliance with state law, you are advised that psychotherapy never includes any form of sexual contact between therapist and client or any client's family member. Other dual relationships are also prohibited.

Licensing Boards Contact Information:

- South Carolina Board of Examiners for Licensed professional Counselors, marital & Family Therapists and Psycho-Educational Specialists: (803) 896-4658, PO Box 11329, Columbia, SC 29211-1329

**IMPORTANT:** You will be asked to sign the last page of this document. Your signature verifies you have read this document and that you consent to treatment. It also documents that you are aware of and understand the above information regarding confidentiality and its limits, the policies regarding fees and that treatment is not always successful and may open up unexpected emotionally sensitive areas.

I understand that my participation in individual, couples or family therapy is voluntary. I may terminate the therapeutic relationship at any time and will discuss any reasons for doing so with Lynn Victory.

I understand that I will be charged \$75 in the event that I do not show up for my appointment or do not cancel my scheduled appointment within 24 hours. I will not be charged if I reschedule my session the same week. If I have a standing appointment weekly or biweekly appointment I understand that I will lose that spot if I no show or cancel without rescheduling that same week on two occasions.

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Name on Card

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Credit Card Number / Expiration / CVV

I understand that all information shared is held in strictest confidence and is only released by my written consent to specific persons or institutions for specific reasons. I further understand that there are some exceptions to confidentiality, which are mandated by state statute.

I have received and read a copy of "OFFICE POLICIES AND INFORMATION" and understand it's content. Under it's terms, I further acknowledge that I consent to and seek treatment with Lynn Victory RD, MA, LPC, until such time as treatment goals are met or other reasons for termination of services have been specified. I understand that psychotherapy is a mutual relationship, which may be terminated by either party for specified reasons.

My signature below confirms that I understand and accept all the information contained in Lynn Victory's "OFFICE POLICIES AND INFORMATION" as well as the "PROFESSIONAL DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT".

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Signature of Client/Financially Responsible Party

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Date

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If more than one individual (i.e.: couple or family) is seeking therapy, please have each of the others sign below. Their signature indicates they have also read the "Office Policies and Information" and the "Professional Disclosure Statement and Consent for Treatment". Additional copies of these will be provided upon request.

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Printed Name & Signature of Co-patient

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Printed Name & Signature of Co-patient